

# executive insights

...management strategies that drive results

SEPTEMBER 2005

## FOCUS ON FINANCE

### The Impact of Price Increase Limits in Managed Care Contracts

William O. Cleverley and James O. Cleverley

Specific carve-outs, stop loss criteria, and other special payment provisions The increasing complexity of many managed care contracts has complicated contract administration, making verification of payment

more difficult for both providers and payers and, as a result, boosting administrative costs A number of hospitals have recently negotiated discounted billed charge contracts to replace older

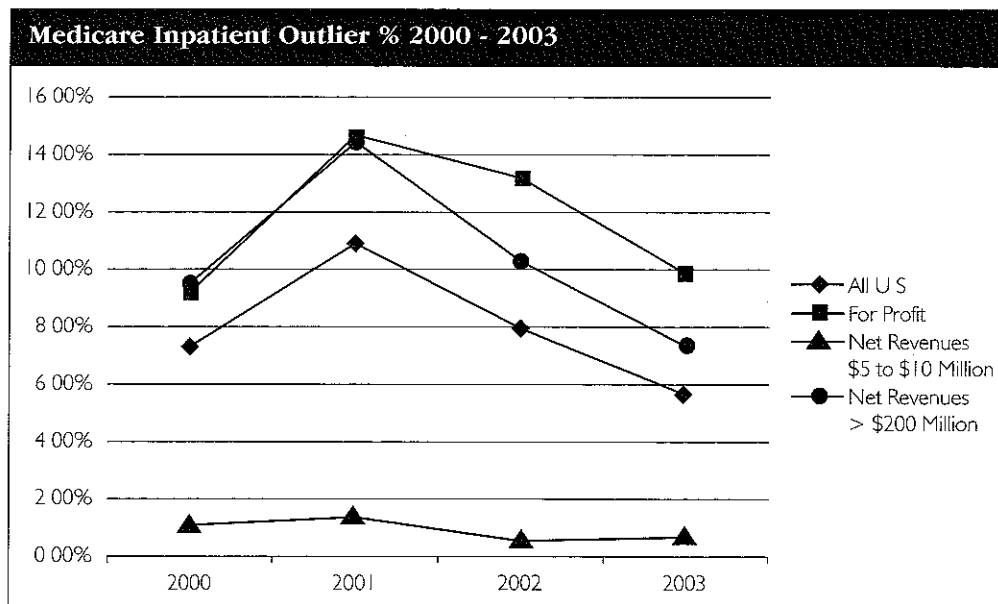
fee schedule arrangements While not necessarily a national trend, this is clearly a step in the right direction In addition to cutting administrative costs, a return to percentage of billed charge arrangements

should help return some sanity to hospital pricing structures

The one problem we have encountered is that hospitals are sometimes so excited about the prospect of a billed charge arrangement that they overlook the possible financial impact of restrictive price increase limits, which payers typically insist on imposing This is a perfectly reasonable practice, as long as providers understand how to select and administer price increase limit provisions

### Finance at a Glance

The graph shows the relationship of Medicare inpatient outlier payments (Worksheet E, Part A, Line 2) to the total of inpatient outlier payments plus other-than-outlier payments (Worksheet E, Part A, Line 1) for 2000 through 2003 The data allow for three observations First, outlier payments appear to be falling since 2001 Second, for-profit hospitals continue to have larger outlier payments Third, smaller hospitals have very low outlier payments It is likely that outlier payments will continue to decline in future years Preliminary data for 2004 suggest that the average has declined further to 4.7 percent



Source: Cleverley and Associates

### How Do Price Increase Limits Work?

The overall objective of a price increase limit provision is fairly straightforward: to prevent a hospital from raising its prices beyond reasonable levels After all, significant price increases could cause a payer to lose large sums of money on negotiated contracts with employers and weaken its



hfma  
healthcare financial management association

Sponsored by

**KaufmanHall**

www.kaufmanhall.com

financial viability. In most cases a price increase limit modifies the discount from billed charges historically contained in the contract. The key contract provision is the allowed rate of increase in the discount. This is used in conjunction with the actual rate of increase to determine whether an adjustment is necessary and, if so, to what extent. The usual payment adjustment can be stated as follows:

$$\text{New Payment \%} = \left[ \frac{1 + \text{Allowed Rate Increase}}{1 + \text{Actual Rate Increase}} \right] \times \text{Present Payment \%}$$

For example, assume a contract provides for payment at 70% of billed charges. The contract has a price increase limit of 5%, and the hospital has raised rates 10%. The revised payment percentage would be 66.82% ( $1.05/1.10 \times 70\%$ ). To see the actual effect of the adjustment, assume a procedure price of \$1,000 is increased to \$1,100 (a 10% increase). The hospital would have been paid \$700 under the old arrangement (70% of \$1,000). It will now be paid \$735 ( $\$1,100 \times 66.82\%$ ). The actual payment increase is \$35, or a

5% increase from the original \$700 base payment, which is the maximum price increase allowed under the contract.

We have run into two interesting price increase limit adjustments. In most contracts that we have seen, there is no upward increase in the payment percentage if the actual rate of increase is less than the allowed. For example, if a 4% rate increase is used, the payer does not increase the payment percentage to 70.67% ( $1.05/1.04 \times 70\%$ ). Second, some contracts feature payer-specific rates of increase, so that while the overall rate of increase may be 10%, the actual rate of increase to the payer might be 15%. Such adjustments can become more severe if prices are loaded more heavily for this payer. This provision is difficult but not impossible to manage.

### Index Selection Is Key

We reviewed a sample of 92 recent contract provisions to document both the range and types of price increase limits being used today. There were two general methods for defining the limits: a specific

percentage increase limit, which ranged from zero to 10%, with an average of 4%; and a specific medical price index. In our sample, we found five specific indexes referenced:

- Consumer Price Index – All Urban (CPI-U)
- CPI Medical Care Index (CPI-MC)
- CPI Medical Services Index (CPI-MS)
- CPI Hospital Services Index (CPI-H)
- Producer Price Index for General Medical and Surgical Hospitals (PPI-H)

A contract using the CPI-U rate of change is very likely to understate the true rate of both cost and charge inflation in the hospital industry, so hospital contract negotiators should avoid using this index unless the contract starts out with a very low initial discount from billed charges. Of the next four indexes, the CPI-H clearly has the highest reported values (7.2% average over four years, compared to 4.5% for the CPI-MC, 4.9% for the CPI-MS, and 4.3 percent for the PPI-H), although the variation has been dropping fairly rapidly since 2002. While the CPI-H historically

has been based on hospital list prices, it has been moving to a net payment method similar to that used in the other indexes, giving negotiators less reason to favor its use. This is because charges have historically increased faster than actual payments.

We suggest moving away from these indexes to measures that reflect the increase in gross charges, as opposed to net payment, specifically:

- Medicare Charge per Discharge Case Mix Adjusted
- Medicare Charge per Outpatient Visit Case Mix Adjusted

Both use public available Medicare files and are based entirely on charges, not payment. The first was very

Robert Fromberg  
Editor-in-Chief

Amy Larsen  
Graphic and Production Designer

EXECUTIVE INSIGHTS is published monthly by the Healthcare Financial Management Association, Two Westbrook Corporate Center, Suite 700, Westchester, IL 60154.

Presorted standard postage paid in Chicago, IL 60607. Copyright 2005 Healthcare Financial Management Association.

Volume 3, Number 9.

Subscriptions are \$90 for HFMA members and \$105 for other individuals and organizations. To subscribe, call 1-800-252-HFMA, ext. 2.

EXECUTIVE INSIGHTS is indexed with Hospital and Health Administration Index and the HealthSTAR database.

Material published in EXECUTIVE INSIGHTS is provided solely for the information and education of EXECUTIVE INSIGHTS readers. HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions in articles and columns in EXECUTIVE INSIGHTS are those of the authors and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear in such articles or columns do not constitute endorsements by HFMA.

ISSN: 1544-2667

### Annual Percentage Change in Price Index Values 2001 to 2004

Index	2001	2002	2003	2004	Average
CPI All Urban	1.6	2.4	1.9	2.6	2.1
CPI Medical Care	4.7	5.0	3.7	4.4	4.5
CPI Medical Care Services	4.8	5.1	4.5	5.0	4.9
CPI Hospital Services	7.2	10.1	6.4	5.2	7.2
PPI Hospital	2.7	5.3	4.9	4.3	4.3
Medicare Charge per Discharge (Case Mix Adjusted)	7.1	10.6	11.5	10.9	10.0
Medicare Charge per Outpatient Visit (Case Mix Adjusted)	NA	22.6	8.3	NA	15.5
Medicare Cost per Discharge (Case Mix Adjusted)	4.8	7.1	5.8	4.9	5.6
Medicare Cost per Outpatient Visit (Case Mix Adjusted)		3.8	3.8		3.8

## The High Cost of Limits Not Aligned with Hospital Charges: A Case Example

A simple example will demonstrate the damaging effects of basing price increase limits on payment or cost rather than on hospital charges. Assume a hospital has 20 patients: 14 governmental, one self-pay, and five commercial. Average cost per patient is \$100 in the first year and increases 5% to \$105 in the second year. Government payers pay \$95 per patient in the first year and \$98 (3.2% increase) in the second year. The self-pay patient is a complete write-off in each year. The commercial payers pay 70% of billed charges, but there is a price increase limit that is based upon cost increases, which are 5% in the second year.

In the first year, the hospital makes a margin of 4% on its cost, or \$80. The price required to generate this level of return is \$214.30, or a mark-up from cost of 214%. Without a price increase limit, the hospital would have to set its price at \$232.01—an 8.26% increase from the first year's price of \$214.30—in order to maintain its 4% margin on cost, or \$84. With a 5% price increase limit in place, the same overall price increase of 8.26% remains; however, the 5% limit on commercial pay patients will

be seen. The effect of this price increase limit will be to reduce the hospital's 70% billed charge recovery from the commercial patients to 67.89% ( $1.05/1.0826 \times 70\%$ ) of billed charges. This raises the contractual allowance from the commercial payer group and reduces earned income by \$24.51. The actual margin is now 2.8%. Increasing the rates above \$232.01 will not increase the amount of net patient revenue, because the effect of the price increase limit will restrict the amount of payment from the commercial group to a 5% increase.

### Financial Effects of Price Increase Limit

	First Year	Second Year No Price Increase Limit Assumed	Second Year Price Increase Limit of 5%
<b>Gross Patient Revenue</b>			
Medicare & Medicaid	\$3,000.17	\$3,248.19	\$3,248.19
Self-Pay	\$214.30	\$232.01	\$232.01
Commercial	\$1,071.49	\$1,160.07	\$1,160.07
Total	\$4,285.96	\$4,640.27	\$4,640.27
<b>Contractual Allowances</b>			
Medicare & Medicaid	\$1,670.17	\$1,876.19	\$1,876.19
Self-Pay	\$214.30	\$232.01	\$232.01
Commercial	\$321.45	\$348.02	\$372.52
Total	\$2,205.92	\$2,456.22	\$2,480.72
<b>Net Patient Revenue</b>	\$2,080.04	\$2,184.05	\$2,159.54
<b>Cost</b>	\$2,000.00	\$2,100.00	\$2,100.00
<b>Net Income</b>	\$80.04	\$84.05	\$59.54
<b>Price Per Patient</b>	\$214.30	\$232.01	\$232.01

similar to the CPI Hospital Services until 2003, when that index began to shift to a net payment methodology. The second shows rate of change for outpatient services; this may be important because many contracts have inpatient fee schedule arrangements but percentage of billed charge outpatient arrangements.

### Limits Based on Charges Are Best

The critical question that needs to be answered is whether price increase limits should be based on changes in hospital costs,

hospital payments, or hospital charges. There is some logic to support all three positions. Some may argue that a cost-based index is best because hospitals should not be permitted to raise their prices at rates faster than cost increases. The counter to this argument is that some payers, especially Medicare and Medicaid, may not be paying their share of cost increases, making it necessary to shift this payment deficit to other charge-based payers.

If you base the rate of permitted price change on net

payments, payers will legitimately argue that forcing them to pay a larger rate of increase than other payers would jeopardize their market position and their overall competitiveness. But again, if other commercial payers do not cover the deficiencies in payments from major government payers, the actual rate of payment change will understate the increase required to keep the hospital financially viable. A specific net payment index that excluded government payers would dash this defense, but there is, so far as we know, no such index.

The third method, based on hospital charges, does restrict increases to the industry average and thus should restrict unusually large increases directed at charge payers. It also permits hospitals to cost shift governmental payment deficiencies to other payers. In many cases, commercial charge payers will be subsidizing government payers, as they do today. The only difference is the time needed to pay for those governmental deficiencies. With charge-based adjustments, the lag in recovery can be much shorter.

*continued on page 6*

## The Impact of Price Increase Limits in Managed Care Contracts

*continued from page 3*

Using a national or regional median for Medicare charge per discharge and Medicare charge per visit, adjusted for case weight, as the basis for price increase limitations will benefit payers and providers alike. Both stand to realize substantial administrative cost savings by using discounted bill charge payment arrangements in managed care contracts, but only if they can protect themselves—payers from substantial price increases and providers from governmental payment deficiencies. A price increase limit provision related to charges in the hospital industry, not payment or cost, will accomplish both goals.

William O. Cleverley, PhD, is president, Cleverley & Associates, Worthington, Ohio. James O. Cleverley is a consultant with the firm (info@cleverleyassociates.com).

## News You Can Use

*continued from page 5*

improvement initiatives to unite national hospital, physician, and nursing organizations; the federal government; accrediting bodies; and private sector experts.

For more information about the SCIP Partnership, go to [www.medqic.org/scip/scip\\_homepage.html](http://www.medqic.org/scip/scip_homepage.html).

*continued from page 4*

menting Section 951 of Pub. L. 108-173 (MMA) to make the Medicare data used in the DSH calculation available to hospitals upon request. CMS will make the information available for either the federal fiscal year or, if a hospital's fiscal year differs, for the months included in the two federal fiscal years that encompass the hospital's cost reporting period.

## Legal Barriers to Using Patient Information to Improve Quality

Misperceptions of the law, as much as the law itself, can hamper quality improvement efforts in health care that rely on the use of patient information, such as identifying patients by race and ethnicity to address racial and ethnic gaps in care. This is one of the findings in *Charting*

*the Legal Environment of Health Information*, a new report by the Robert Wood Johnson Foundation and the George Washington University School of Public Health and Health Services.

Two versions of the report, a summary and a full version, are available online at [www.qwumc.edu/sphhs/healthpolicy](http://www.qwumc.edu/sphhs/healthpolicy) and [www.rwjf.org](http://www.rwjf.org).

## Executive Summary: CMS Final Rule for Hospital IPPS and FY06 Rates

### New Technology Add-On Payments

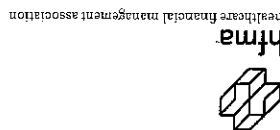
New technology add-on payments are limited to the lower of 50 percent of the costs of the technology or 50 percent of the costs in excess of the DRG payment for the case. CMS is approving two of the new technology applications that were filed for FY06: Restore® Rechargeable Implantable Neurostimulator and GORE TAG. CMS will continue to make

add-on payments in FY06 for an FY05 new technology: Kinetra™ implants. They estimate that overall FY06 payments will increase by \$6.01 million, \$16.61 million, and \$12.82 million, respectively, for these new technologies.

Kevin Pleasant is director, research and development, HEALTH DATA FOCUS division, Innovative Health Solutions, LLC, Red Bank, NJ (kpleasant@ihsinfo.com).

**KaufmanHall**

Sponsored by



HFMA  
Two Westbrooke Corporate Center  
Suite 700  
Westchester, IL 60154

executive insights  
management strategies that drive results

PRESORTED  
STANDARD  
U.S. POSTAGE  
PAID  
PERMIT NO. 2862  
CHICAGO, IL